

Complete Summary

GUIDELINE TITLE

Newborn and infant hearing loss: detection and intervention.

BIBLIOGRAPHIC SOURCE(S)

Newborn and infant hearing loss: Detection and intervention. Pediatrics 1999 Feb; 103(2):527-30. [30 references]

COMPLETE SUMMARY CONTENT

SCOPE

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RECOMMENDATIONS

EVIDENCE SUPPORTING THE RECOMMENDATIONS

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

IMPLEMENTATION OF THE GUIDELINE

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT

CATEGORIES

IDENTIFYING INFORMATION AND AVAILABILITY

SCOPE

DISEASE/CONDITION(S)

Hearing loss

GUIDELINE CATEGORY

Evaluation

Screening

Treatment

CLINICAL SPECIALTY

Pediatrics

INTENDED USERS

Advanced Practice Nurses

Physician Assistants

Physicians

Public Health Departments

GUIDELINE OBJECTIVE(S)

- To endorse the implementation of universal newborn hearing screening.
- To review the primary objectives, important components, and recommended screening parameters that characterize an effective universal newborn hearing screening program.

TARGET POPULATION

Newborn infants

INTERVENTIONS AND PRACTICES CONSIDERED

Universal newborn hearing screening program (UNHSP):

1. Initial screening with an acceptable methodology such as evoked otoacoustic emissions (EOAE); auditory brainstem response (ABR), either alone or in combination
2. Tracking and follow-up
3. Identification
4. Intervention
5. Evaluation

MAJOR OUTCOMES CONSIDERED

1. Screening test performance characteristics (sensitivity, specificity)
2. Proportion of all infants screened
3. Referral rate
4. Follow-up rate

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Not stated

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not applicable

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Screening (Fletcher, Fletcher, & Wagner, 1988; Spivak, 1998; Davis et al., 1997)

The following are guidelines for the screening element of a universal newborn hearing screening program (UNHSP):

- Universal screening has as its goal that 100% of the target population, consisting of all newborns, will be tested using physiologic measures in both ears. A minimum of 95% of newborns must be screened successfully for it to be considered effective. (Barsky-Firsker & Sun, 1998; Mason & Herrmann, 1998; Vohr et al., 1998)
- The methodology should detect, at a minimum, all infants with significant bilateral hearing impairment, i.e., those with hearing loss ≥ 35 -decibel in the better ear. (Nothorn & Downs, 1984; Barsky-Firsker & Sun, 1998; Mason & Herrmann, 1998)
- The methodology used in screening should have a false-positive rate, i.e., the proportion of infants without hearing loss who are labeled incorrectly by the screening process as having significant hearing loss, of $\leq 3\%$. The referral rate

for formal audiologic testing after screening should not exceed 4%. (Barsky-Firsker & Sun, 1998; Downs, 1995; Mason & Herrmann, 1998; Mehl & Thomson, 1998; Vohr et al., 1998)

- The methodology used in screening ideally should have a false-negative rate, i.e., the proportion of infants with significant hearing loss missed by the screening program, of zero. (Vohr et al., 1998; Watkin, 1996)
- Until a specific screening method(s) is proved to be superior, the Academy defers recommendation as to a preferred method. Currently, acceptable methodologies for physiologic screening include evoked otoacoustic emissions (EOAE) and auditory brainstem response (ABR), either alone or in combination. Both methodologies are noninvasive, quick (<5 minutes), and easy to perform, although each assesses hearing differently. EOAE measures sound waves generated in the inner ear (cochlea) in response to clicks or tone bursts emitted and recorded via miniature microphones placed in the external ear canals of the infant. Although EOAE screening is even quicker and easier to perform than ABR, EOAE may be affected by debris or fluid in the external and middle ear, resulting in referral rates of 5% to 20% when screening is performed during the first 24 hours after birth. ABR measures the electroencephalographic waves generated in response to clicks via three electrodes pasted to the infant's scalp. ABR screening requires the infant to be in a quiet state, but it is not affected by middle or external ear debris. Referral rates <3% may be achieved when screening is performed during the first 24 to 48 hours after birth. Referral rates <4% are generally achievable with EOAE combined with automated ABR in a two-step screening system or with automated ABR alone. (Barsky-Firsker & Sun, 1998; Downs, 1995; Mason & Herrmann, 1998; Mehl & Thomson, 1998; Vohr et al., 1998) In a two-step system using EOAE as the first step, referral rates of 5% to 20% for repeat screening with ABR or EOAE may be expected. The second screening may be performed before discharge or on an outpatient basis within 1 month of age. Screening should be conducted before discharge from the hospital whenever possible.
- Each birthing hospital should establish a UNHSP with a designated medical (physician) director and sufficient staff to perform the following:
 1. Develop the screening protocol and select the screening method(s).
 2. Provide appropriate training and monitoring of the performance of staff responsible for performing hearing screening.
 3. Provide the parents or guardians information concerning the screening procedure, costs, potential risks of hearing loss, and the benefits of early detection and intervention.
 4. Establish a system that ensures confidentiality and allows the parents or guardians the opportunity to decline hearing screening. In most institutions, general hospital consent obtained at time of admission is considered to be inclusive of routine care, such as newborn hearing screening.
 5. Ensure that all individuals performing hearing screening are trained properly in the performance of the tests, the risks including psychological stress for the parents, infection control practices, and the general care and handling of infants in hospital settings according to established hospital policies and procedures. (American Academy of Pediatrics [AAP]/American College of Obstetricians and Gynecologists [ACOG], 1997)
 6. Establish clear guidelines for responsibility of documenting the results of the screening procedure.

7. Develop mechanisms for communicating results of screening in a sensitive and timely manner to the parents and the child's physician(s). If repeat screening is necessary after discharge from the hospital, ensure that appropriate follow-up is provided.
8. Work with local, state, and national monitoring systems to identify all cases of significant hearing loss occurring in infants designated initially as free of hearing impairment by the UNHSP (false-negatives).
9. Secure funding for the program. Funding through third-party reimbursement is essential to cover the costs of the UNHSP, including the initial screen(s), as well as of diagnostic and intervention services. The cost of complete screening in statewide programs ranges from approximately \$7 to \$26 per infant screened. (Spivak, 1998) Additional studies (some of which are ongoing) are necessary to quantify costs of tracking, diagnostic, and intervention services. (Downs, 1994; Stevens et al., 1998; Maxon et al., 1993)
10. Collect critical performance data to ensure that each UNHSP meets the criteria specified in this statement. These data should be reported in a regular and timely manner to a statewide central monitoring program.

Tracking and Follow-up (Spivak, 1998; Davis et al., 1997; White, 1996; Downs, 1994; Stevens et al., 1998; Maxon et al., 1993)

The following are guidelines for the tracking and follow-up elements of a UNHSP:

- Universal screening has as its goal that there will be 100% follow-up of all infants referred for formal audiologic assessment and for all infants not screened initially in the birthing hospital whose parents did not refuse screening. A minimum of 95% successful follow-up is required for a UNHSP to be considered an effective screening program.
- State departments of health, in coordination with programs mandated by Part C of the Individuals with Disabilities Education Act, should:
 1. Establish and maintain a central monitoring system for all hearing screening programs within the state. Critical performance data, including number of infants born; the proportion of all infants screened; the referral rate; the follow-up rate; the false-positive rate; and the false-negative rate should be collected in a timely manner.
 2. Establish and maintain a tracking program that monitors all referrals and misses. Monitoring should ensure that children with significant hearing loss are not missed, i.e., all children designated as free of hearing loss by the UNHSP, but who are later detected to have significant hearing loss, are identified by the statewide tracking program.
 3. Develop mechanisms for communicating results of follow-up activities with the parents/guardians and the child's physician(s), audiologist, and speech language therapist. (American Academy of Pediatrics [AAP], 1992)
 4. Ensure that hearing screening is performed on all out-of-hospital births.
 5. Report the screening performance parameters of individual hospital-based UNHSPs within the state in a timely manner.
 6. Report critical performance data of each UNHSP (without personal identifiers) to a national Early Hearing Detection and Intervention

monitoring program established by the Centers for Disease Control and Prevention (CDC).

Identification and Intervention (Spivak, 1998; Davis et al., 1997; White, 1996; Downs, 1994; Stevens et al., 1998; Maxon et al., 1993)

The following are guidelines for the identification and intervention element of a UNHSP:

- Universal screening has as its goal that 100% of infants with significant congenital hearing loss shall be identified by 3 months of age and shall have appropriate and necessary intervention initiated by 6 months of age. (Yoshinaga-Itano et al., 1998; Robinshaw, 1995; Robinshaw, 1996)
- Appropriate and necessary care for the infant with significant hearing loss should be directed and coordinated by the child's physician within the medical home, with support from appropriate ancillary services. (American Academy of Pediatrics [AAP], 1992)
- A regionalized approach to identification and intervention for infants with significant hearing loss is essential, ensuring access for all children with significant hearing loss to appropriate expert services. It is recognized that professionals with demonstrated competency to provide expert services in the identification and intervention of significant hearing loss in young infants are not available in every hospital or community. The child's physician, within the medical home, working with the state department of health must ensure that every infant with significant hearing loss is referred to the appropriate professional(s) within the regionalized system.
- It is anticipated that there will be increased demand for qualified personnel to provide age-appropriate identification and intervention services for young infants with significant hearing loss. As a result, there will be a need for the training and education of additional expert care providers.

Evaluation (Spivak, 1998; Davis et al., 1997; White, 1996; Downs, 1994; Stevens et al., 1998; Maxon et al., 1993)

The following are guidelines for the evaluation element of a UNHSP:

- The UNHSPs should be evaluated on an ongoing and regular basis by the state monitoring system for performance with regard to parameters enumerated in "Screening" above.
- Tracking and follow-up should be evaluated on an ongoing and regular basis by the state monitoring system, as well as through a national monitoring system to be established by the CDC.
- Intervention services should be evaluated on an ongoing and regular basis by the state department of health to ensure that sufficient expert services are available for children identified with significant hearing loss, that the services are accessible to the children in need, and that outcomes from interventions provided are effective.

Other Recommendations and Issues

The following are additional recommendations of the Academy for developing a UNHSP:

- The Academy recommends that each American Academy of Pediatrics chapter assume a leadership role in state-based efforts to promote optimal implementation of UNHSPs. Effective statewide programs require broad-based support and collaboration. Collaboration should include (but not be limited to) appropriate professional organizations, parent advocacy groups, deaf and hard-of-hearing adults, physicians, audiologists, speech and language therapists, nurses, administrators, payers, legislators, and state departments of health and special education.
- The Academy shall identify, develop, and disseminate educational materials regarding effective hearing screening programs. (Spivak, 1998)
- To promote additional research and the development of the needed infrastructure to provide universal newborn hearing screening, the Academy recommends the following:
 1. The National Institutes of Health support ongoing research to improve the efficacy of screening, identification, and intervention.
 2. The Health Resources and Services Administration promote the development of a state-based early hearing loss identification and intervention network.
 3. The CDC establish and maintain a national monitoring and evaluation program for early hearing loss identification and intervention.

Physicians should provide recommended hearing screening, not only during early infancy but also through early childhood for those children at risk for hearing loss (e.g., history of trauma, meningitis) and for those demonstrating clinical signs of possible hearing loss. (Davis, 1997; Davis & Wood, 1992). Although most hearing loss in children is congenital (i.e., present at birth), a significant portion of hearing loss is acquired after birth. (Centers for Disease Control and Prevention, 1997; Parving, 1991; Sorri & Rantakallio, 1985). Regardless of the age of onset, all children with hearing loss require prompt identification and intervention by appropriate professionals with pediatric training and expertise.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

[References open in a new window](#)

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Screening by high-risk registry alone (eg, family history of deafness) can only identify ~50% of newborns with significant congenital hearing loss. Reliance on physician observation and/or parental recognition has not been successful in the past in detecting significant hearing loss in the first year of life.

Universal screening has as its goal that 100% of infants with significant congenital hearing loss shall be identified by 3 months of age and shall have appropriate and necessary intervention initiated by 6 months of age.

POTENTIAL HARMS

A proportion of infants without hearing loss will be labeled incorrectly by the screening process as having significant hearing loss. These infants will require additional testing. The goals of universal screening programs include maintaining this false-positive rate at $\leq 3\%$ and the referral rate for formal audiologic testing after screening at $\leq 4\%$.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Newborn and infant hearing loss: Detection and intervention. Pediatrics 1999 Feb; 103(2):527-30. [30 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1999 Feb

GUIDELINE DEVELOPER(S)

American Academy of Pediatrics - Medical Specialty Society

SOURCE(S) OF FUNDING

Not stated

GUIDELINE COMMITTEE

Task Force on Newborn and Infant Hearing

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Task Force Members: Allen Erenberg, MD, AAP Delegate to Joint Committee on Infant Hearing; James Lemons, MD, Chairperson, AAP Committee on Fetus and Newborn; Calvin Sia, MD, Chairperson, Project Advisory Committee for the Medical Home Program for Children With Special Needs; David Tunkel, MD, Chairperson, AAP Section on Otolaryngology-Bronchoesophagology; Philip Ziring, MD, Chairperson, AAP Committee on Children With Disabilities

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

An update is not in progress at this time.

AAP Policies are reviewed every 3 years by the authoring body, at which time a recommendation is made that the policy be retired, revised, or reaffirmed without change. Until the Board of Directors approves a revision or reaffirmation, or retires a statement, the current policy remains in effect.

GUIDELINE AVAILABILITY

Electronic copies: Available from the [American Academy of Pediatrics \(AAP\) Policy Web site](#).

Print copies: Available from AAP, 141 Northwest Point Blvd., P.O. Box 927, Elk Grove Village, IL 60009-0927.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on January 7, 2000. The information was verified by the guideline developer on January 21, 2000.

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